STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G173	A. BUILDING _____ B. WING _____	04/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN	4815 CHESAPEAKE STREET, NW WASHINGTON, DC 20016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from April 2, 2008 through April 4, 2008. The survey was initiated using the fundamental survey process. A random sample of two clients was selected from a resident population of four women with various disabilities. Client #1 had been admitted to the facility on October 29, 2007. A focused review of Client #3's admission documentation was also conducted (admitted to the facility on July 27, 2007). The findings of the survey were based on observations, interviews with clients and staff in the home and at one day program, as well as a review of client and administrative records, including incident reports.	W 000	1	
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview, review of incident reports and review of client records, the facility failed to ensure that an allegation of client mistreatment/ verbal abuse was reported immediately to the administrator and to the State agency, in accordance with facility policies. The findings include: On April 2, 2008, the Residential Team Leader (RTL, aka House Manager) was interviewed for the entrance conference, beginning at 9:00 AM.	W 153		

RECEIVED
2008 MAY 15 P 3:08
DEPARTMENT OF HEALTH
HEALTH REGULATION
ADMINISTRATION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Angela Bowling for Previous M. Brown	Program Director	5-14-08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 153	Continued From page 1 At approximately 9:30 AM, she described an incident in which Client #1 arrived at her day program one morning in tears. She told day program staff that "she was very upset" about how residential staff talked to her. The client was in tears when she spoke with the RTL by telephone. The RTL said that the incident had been reported and investigated promptly. When asked about the outcome, the RTL stated "that person is no longer here" and the Incident Management Coordinator (IMC) had in-serviced staff on how to speak with the clients using a proper tone of voice and respect. [Note: Neither the incident report(s) or the investigation report were available for review in the facility on that day.] On April 2, 2008, the IMC was interviewed in the facility, beginning at 5:04 PM. He described how a staff person telephoned him on a Friday morning to inform him that Client #1 had been "upset, crying." Staff had allegedly said something that upset her on the night before. The IMC came to the facility and interviewed the client. It was unclear as to when or where the incident had occurred. There was some evidence that the incident had occurred the night before, during an outing to a nightclub. Client #1 alleged that staff had said "don't be lazy" or something to that effect. The IMC then described another incident that reportedly occurred the following week. He spoke by telephone with staff in the home about in-service training on sensitivity issues. The staff then talked about the training while they were driving Client #1 in the facility van. It was on that morning, the second incident, that the client arrived at day program upset that staff had talked	W 153	All staff were in-serviced on "Sensitivy" by the Incident Management Coordinator, and an investigation was completed as well. However, the investigation was not filed in the facility book of standards and compliance. Refer to attachment #1 a & b. In the future, the incident management coordinator, and the facility management team will ensure that the records are filed in the books, and availlable upon request. The Psycholigist is still in the process of updating individual #1 Psychological assessment, to include Sensitivy issues.	5-19-08

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W 153	Continued From page 2 about her while they were all in the van. On April 3, 2008, at 3:28 PM, the IMC arrived in the facility and presented two (2) incident reports, dated February 6, 2008 and February 14, 2008, and the corresponding investigation report, dated February 20, 2008. Immediate review of the documents revealed the following: 1. Although the investigation report indicated that the first time the client was in tears was on Friday, February 1, 2008, there was no evidence that staff prepared an incident report that day, in accordance with facility Policy Number 170. The incident report for that complaint was dated February 6, 2008, five (5) calendar days (3 business days) after the client first made her allegation. 2. There was no documented evidence that the facility's administrator was notified immediately of Client #1's February 1, 2008 allegation. 3. Pre-survey review of State agency records followed by an onsite review of relevant documents in the facility failed to show evidence that the State agency was notified of the client's February 1, 2008 complaint. 4. There was no documented evidence that the facility's administrator was notified immediately of Client #1's second complaint, on February 14, 2008. 5. Pre-survey review of State agency records followed by an onsite review of relevant documents in the facility failed to show evidence that the State agency was notified of the client's February 14, 2008 complaint.	W 153	1 All staff were retrained on the incident reporting. Refer to attachment # 2 In the future, the facility will ensure that all incidents are reported on a timely manner as stipulated in the incident management policy. The facility's administrator will be immediately notified of all of the incidents that occur in the home. In the future the house management will ensure that the administrator is notified on all of the incidents. The facility's administrator will initial the incident report as indication of aknowledgment. All occuring incidents will be reported to the State Agency. In the future, the facility will ensure that all incidents are documented, and reported to the State Agency. Refer to W 153 (2) P. 3 Refer to W 153 (3) P. 3	4-11-08

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W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that investigations were reported to the administrator or designated representative within five working days of the incident, for one of the two clients in the sample. (Client #1) The finding includes: Cross-refer to W153. On April 2, 2008, interviews with the Residential Team Leader and the Incident Management Coordinator revealed two (2) incidents in which Client #1 cried and made allegations that staff had spoken with and/or about her in a disrespectful manner. The incidents had occurred on February 1 and February 14, 2008. The earliest dated incident report and staff witness statements were dated February 6, 2008. Both incidents were combined into one investigative report document, dated February 20, 2008. There was no evidence that Client #1's February 1, 2008 allegation of staff mistreatment was investigated within five working days, with the results reported to the administrator in accordance with the regulation and the facility's policies.	W 156	All staff were in-serviced on "Sensitivy" by the Incident Management Coordinator, and an investigation was completed as well. However, the investigation was not filed in the facility book of standards and compliance. Refer to attachment #1 a & b. In the future, the incident management coordinator, and the facility management team will ensure that the records are filed in the books, and availlable upon request.	
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a	W 159		

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W 159	Continued From page 4 qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the Qualified Mental Retardation Professional (QMRP) failed to coordinate and monitor programs and services, for two of the four clients residing in the facility. (Clients #2 and #3) The findings include: 1. Cross-refer to W331.2. The QMRP failed to ensure the coordination of services between a hospital emergency room (ER) and the facility, as follows: On April 2, 2008, beginning at 10:31 AM, review of incident reports in the facility revealed that Client #2 went to the ER on July 8, 2007 after staff observed something different with her chest. Diagnostic performed at the hospital included a chest x-ray that revealed a "probable hiatal hernia." An incident investigation report, dated November 15, 2007 and prepared by the Incident Management Coordinator, following another ER visit reflected several diagnoses, including a "large hiatal hernia." On April 3, 2008, beginning at 2:07 PM, review of Client #2's medical records failed to show evidence that the medical team had addressed the hospital's findings to date. On April 4, 2008, at 3:45 PM, the RN who had prepared a January 31, 2008 Nursing Assessment was asked about Client #2's reported hiatal hernia. He examined the hospital documents from July 2007 and acknowledged that he was previously unaware of	W 159	Once the individual is discharged from the ER/hospital, the house manager informs the medical team that usually reports to the house to address the issues, concerns, and follow up on the findings and recommendations. In the future, the facility medical team will ensure that all the hospital findings are are addressed on a timely manner.	

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W 159	Continued From page 5 the hospital's findings. He showed it to the Director of Nursing, who was present in the facility at the time. She too was unaware of the findings. 2. The QMRP failed to ensure that baseline behavioral data was collected for Client #3, as follows: On April 2, 2008, at 7:32 AM, Client #3 walked out of her bedroom and came through the living room on her way to the dining room. She stopped next to a floor lamp in the living room, leaned forward and placed her nose (briefly) against the lamp shade, before continuing to the dining room. A moment later, she bent over and touched her nose to a bouquet of artificial flowers that were in the center of the table. At approximately 8:15 AM, she repeated this behavior, when she placed her nose briefly against the back of her dining room chair. During the entrance conference, at 9:10 AM that morning, the Residential Team Leader (RTL, aka House Manager) indicated that the client had exhibited the nose-ing behavior since she was admitted to the facility in June 2007. The client would rub her nose on facility walls, leaving mucous on the walls. This reportedly had been especially heavy in December 2007, when Client #3 was treated for a sinus infection. The behavior, however, had not yet been assessed by their psychologist. The RTL further stated that the psychologist was expected to come to the facility to assess the client's nose-ing behavior and to provide appropriate recommendations. Although Client #3 was not in the sample, a focused review of her admission documentation	W 159	Staff did collect data to baseline individual #3 behaviors of concerns for 30 days as recommended by the Psychologist; however, based on the data collection, there was no sufficient data that indicated the intensity of this behavior,and consequently to draft a BSP;also individual #3 was diagnosed with Sinus. Since the behavior has reoccured, the Psychologist is updating individual #3 baseline for her behaviors of concerns. 5-19-08 In the future, the facility will ensure that all behaviors are address as they occur.	

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W 159	Continued From page 6 was conducted because she had been admitted to the facility within the past twelve (12) months. On April 4, 2008, beginning at 2:40 PM, review of Client #3's record confirmed that she was admitted on June 29, 2007. A psychologist assessed her shortly thereafter. In the Psychological Evaluation, dated July 30, 2007, the psychologist recommended collecting baseline data, to be reviewed at the end of August 2007. Further review of the record showed no evidence that staff had collected baseline data since then or that the psychologist had reviewed Client #3's behavioral needs since July 2007.	W 159	Staff did collect data to baseline individual #3 behaviors of concerns for 30 days as recommended by the Psychologist; however, based on the data collection, there was no sufficient data that indicated the intensity of this behavior, and consequently to draft a BSP; also individual #3 was diagnosed with Sinus. Since the behavior has reoccured, the Psychologist is updating individual #3 baseline for her behaviors of concerns. In the future, the facility will ensure that all behaviors are address as they occur.	5-19-08
W 268	483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. This STANDARD is not met as evidenced by: Based on observation and record review, facility staff failed to consistently promote client independence, for one of the two clients in the sample. (Client #1) The finding includes: On April 2, 2008, at 8:29 AM, Client #1, who was seated in a wheelchair, informed staff that she needed to use the restroom. A direct support staff pushed the client's wheelchair from the dining room to the restroom. The client did not participate in propelling her wheelchair and staff was not observed offering her encouragement to do so. During the entrance conference that morning, at approximately 9:15 AM, the	W 268	All staff were inserviced on the active treatment with emphasis of promoting independence. Refer to attachment #3 In the future the facility management will ensure that staff assist the individual, and encourage the activities that promote independence.	4-29-08

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W 268	Continued From page 7 Residential Team Leader stated that Client #1 required assistance with transfering in and out of her wheelchair to the commode and to her bed; otherwise, she was independent with her wheelchair. Client #1 was observed at her day program later that day. At 12:47 PM, she was observed propelling her wheelchair manually, and independently, in the hallway from her day treatment room to the cafeteria. At 1:15 PM, Client #1 propelled her chair out of the lunchroom independently. The next morning, and throughout the remainder of the survey, staff in the home were observed pushing the client's wheelchair without asking her first if she wanted assistance. On April 3, 2008 at 9:20 AM, review of Client #1's Occupational Therapy assessment, dated November 17,1 2007 revealed that she was independent in the use of her wheelchair but relied on staff assistance with transfers. Similar assessment findings were documented in Physical Therapy Assessments dated November 26, 2007 and March 21, 2008.	W 268	All staff were inserviced on the active treatment with emphasis of promoting independence. Refer to attachment #3 In the future the facility management will ensure that staff assist the individual, and encourage the activities that promote independence.	4-29-08
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure nursing services in accordance with client needs, for two of the two clients in the sample. (Clients #1 and #2) The findings include:	W 331	All staff were inserviced on the active treatment with emphasis of promoting independence. Refer to attachment #3 In the future the facility management will ensure that staff assist the individual, and encourage the activities that promote independence.	4-29-08

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W 331	Continued From page 8 1. On April 2, 2008, the Residential Team Leader (RTL, aka House Manager) was interviewed for the entrance conference, beginning at 9:00 AM. At approximately 9:15 AM, she indicated that Client #1 required assistance with transferring in and out of her wheelchair to the commode and to her bed; otherwise, she was independent with her wheelchair. Beginning at 10:31 AM, review of incident reports in the facility revealed that on January 28, 2008, at 8:15 AM, direct support staff working with Client #1 discovered a blister on the top of her right foot. The client reportedly told the staff that her foot had slid "underneath the heater on the floor" while transferring from her wheelchair onto the commode earlier that day. a. On April 3, 2008, beginning at 9:17 AM, Client #1's Occupational Therapy assessment, dated November 17, 2007, Physical Therapy assessments, dated November 26, 2007 and March 21, 2008, and annual Individual Support Plan, dated November 29, 2007, verified that the client required staff assistance while transferring from her wheelchair to the commode. The March 21, 2008 PT assessment recommended use of a gait belt for the staff to "assist with transfers." [Note: The gait belt was available for use during the survey.] The PT also stated the client "...should be supervised closely for all transfers." However, further review of these and the client's other health and habilitation records failed to show evidence of instructions or a protocol that specified how staff were to assist during the transfer and/or how to prevent falls. b. On April 4, 2008, at 2:56 PM, review of Client #1's Health Management Care Plan (HMCP), dated March 13, 2007, revealed that it did not	W 331	All staff were inserviced on the individual monitoring, and on the use and importance of the adaptive adaptive equipment (gait belt) Refer to attachment # 4 In the future, the facility will ensure that the staff use the adaptive as recommended by the Physical Therapist.	4-29-08

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W 331	Continued From page 9 address the level of staff assistance needed for transfers, nor did it address the use of her lower leg braces (for edema) or fall precautions. There was no evidence that facility nurses revised/ updated the client's HMCP after she sustained the burn injury on January 28, 2008, more than 2 months earlier. It should be noted that review of staff training records on April 4, 2008, beginning at 4:00 PM, revealed no evidence that the PT had provided training for staff on the use of the client's gait belt and/or safety precautions, lifting and transfer techniques. The most recent documented staff in-service training on lifting and transfer techniques had been provided by an LPN in October and November 2006. It should be further noted that although the RTL said there had been staff assisting Client #1 in the bathroom at the time of the burn, there was no evidence that the incident had been investigated, in accordance with facility policies. 2. On April 2, 2008, beginning at 10:31 AM, review of incident reports in the facility revealed that Client #2 went to the emergency room (ER) on July 8, 2007 after staff observed something different with her chest. Diagnostic performed at the hospital included a chest x-ray that revealed a "probably hiatal hernia." On November 10, 2007, Client #2 returned home from another hospitalization, only to show signs of discomfort. She was not eating and did not have a bowel movement. The client was taken that day to a hospital ER via 911 ambulance. The discharge papers dated November 13, 2007 reflected fecal impaction and anal stricture. The incident investigation report, dated November 15, 2007	W 331	Individual #1 Health Management Care Plan was revised, and included the use of the lower leg braces, and fall precautions. In the future, the facility nursing team will ensure that the HMCP is updated on a timely manner, and included all of the pertaining diagnoses. The PT did inservice the staff on Refer to attachment #4 In the future, the facility will ensure that staff are inserviced on the safety precautions on an ongoing basis. Once the individual is discharged from the ER/hospital the house manager informs the medical team that usually reports to the house to address the issues, concerns, and follow up on the findings and recommendations. In the future, the facility medical team will ensure that all the hospital findings are are addressed on a timely manner.	4-15-08 4-24-08

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W 331	Continued From page 10 and prepared by the Incident Management Coordinator, reflected those diagnoses as well as a "large hiatal hernia." On April 3, 2008, beginning at 2:07 PM, review of Client #2's medical records failed to show evidence that the medical team had addressed the hospital's findings to date. The client's HMCP, dated February 15, 2008, did not reflect the diagnosis and/or how the condition would be managed. The client's annual Medical Evaluation, dated February 15, 2008, did not reflect a diagnosis of hiatal hernia, nor did the client's annual Nursing Assessment, dated January 31, 2008. A draft copy of a February 2008 annual ISP (still pending review and approval) made no mention of a hiatal hernia. On April 4, 2008, at 3:45 PM, the RN who had prepared the January 31, 2008 Nursing Assessment was asked about Client #2's reported hiatal hernia. He examined the hospital documents from July 2007 and acknowledged that he was previously unaware of the hospital's findings. He showed it to the Director of Nursing, who was present in the facility at the time. She too was unaware of the findings. She indicated that the information would be shared with the primary care physician. At the time of the survey, the facility had not determined what, if any, precautions, treatment plan or further diagnostics might be indicated for Client #2's reported hiatal hernia.	W 331	Individual #1 Health Management Care Plan was revised, and includes all of the diagnoses In the future, the facility nursing team will ensure that the HMCP is updated on a timely manner, and included all of the pertaining diagnoses. Once the individual is discharged from the ER/hospital the house manager informs the medical team that usually reports to the house to address the issues, concerns, and follow up on the findings and recommendations. In the future, the facility medical team will ensure that all the hospital findings are are addressed on a timely manner.	4-15-08
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.	W 368		

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W 368	Continued From page 11 This STANDARD is not met as evidenced by: Based on observation, interview and record verification, the facility failed to ensure that drugs were administered in accordance with physician's orders, for one of the four clients residing in the facility. (Client #4) The finding includes: Cross-refer to W369.4. On April 2, 2008, Client #4 was observed making a deep, gurgling cough at various times during the morning and afternoon. It was later determined that she had physician's orders for "Bromatane DX cough syrup, 5 ml by mouth, 4 times daily as needed for congestion." Client #4 did not receive cough syrup in accordance with physician's orders.	W 368	1	
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that medications were administered as prescribed, for three of the four clients residing in the facility. (Clients #1, #2 and #4) The findings include: The morning medication administration pass was observed on April 2, 2008, beginning at 7:13 AM. The following errors were observed:	W 369		

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	09G173	A. BUILDING _____ B. WING _____	04/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN	4815 CHESAPEAKE STREET, NW WASHINGTON, DC 20016

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W 369	Continued From page 12 1. At 7:16 AM, the trained medication employee (TME) squeezed 1 spray of Flonase nasal spray into Client #1's left and right nostrils. The client, however, did not take in a breath at the appropriate moments when the nurse squeezed the nasal spray bottle. The TME did not offer the client any instructions during this process. The TME was not observed using effective means to ensure that Client #1 received her prescribed nasal spray in accordance with the physician's orders. 2. At 7:55 AM, the TME poured Client #2's liquid Dilantin into a medicine cup and placed it on top of a file cabinet. The client's orders were to receive 4 ml of liquid, or 100 mg Dilantin. As the TME reached for the medicine cup to take to the client, who was seated at the breakfast table in her wheelchair, she indicated that she was about to administer the medication. Observation of the medicine cup revealed that there was only 2.5 ml of liquid poured. After this was brought to the TME's attention, she added another 1.5 ml to equal 4 ml. 3. At 7:48 AM, the TME squeezed 1 spray of Advair discus inhaler into Client #4's mouth. The client, however, did not take in a breath at the appropriate moment when the nurse squeezed the Advair discus. The TME did not offer the client any instructions during this process. The TME was not observed using effective means to ensure that Client #4 received her prescribed medication in accordance with the physician's orders. 4. At 7:55 AM, Client #4 was observed making a deep, gurgling cough. She gave four coughs repeatedly at that time. The client coughed again	W 369	All of the facility TMEs were trained on the medication administration refer to attachment #5 In the future, the facility will ensure that all of medications are administrated as prescribed by the physician. All of the facility TMEs were trained on the medication administration refer to attachment #5 In the future, the facility will ensure that all of medications are administrated as prescribed by the physician. All of the facility TMEs were trained on the medication administration refer to attachment #5 In the future, the facility will ensure that all of medications are administrated as prescribed by the physician.	4-29-08 4-29-08 4-29-08

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W 369	Continued From page 13 at 8:13 AM and several more times at 9:03 AM. Observations later that day included several deep, bubbly coughs in succession at 4:19 PM. At that time, her face turned red as she coughed. Verification of the medication pass on the following day, April 3, 2008, revealed PRN ("as needed") physician's orders for "Bromatane DX cough syrup, 5 ml by mouth, 4 times daily as needed for congestion." Client #4 had not been observed receiving cough syrup the previous day when she coughed. At 1:28 AM, interview with the RN revealed that the cough syrup should be administered if she had "a persistent cough, that doesn't stop." When asked if she should have taken the cough syrup when she had a deep, bubbly cough, he replied "yes," that would indicate congestion. At approximately 4:40 PM, interview with the Director of Nursing yielded similar discussion. Coughing would help the client clear her lungs of congestion. She affirmed that Bromatane was an expectorant, not a suppressant; therefore it should have been administered in accordance with physician's orders.	W 369	All of the facility TMEs were trained on the medication administration refer to attachment #5 In the future, the facility will ensure that all of medications are administrated as prescribed by the physician.	4-29-08

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I 000	INITIAL COMMENTS A licensure survey was conducted from April 2, 2008 through April 4, 2008. A random sample of two residents was selected from a resident population of four women with various degrees of disabilities. A focused review of a third resident's admission documentation also was conducted. The findings of this survey were based on observations at the group home and at one day program, interviews with residents, day program and residential staff as well as the review of clinical and administrative records, including incident reports.	I 000		
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to train all staff on specialty areas such as recreation and total communication. The findings include: On April 4, 2008, beginning at 4:00 PM. review of the staff in-service training records and interview with the Residential Team Leader (aka House Manager)revealed no evidence that the GHMRP trained its direct support staff on the following topics: - physical therapy,	I 229	Program Director	

Health Regulation Administration

Angelo Palmieri for Brenda M. Brown — TITLE — (X6) DATE 5-14-08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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I 229	Continued From page 1 - recreation, and - sexuality. It should be noted that an incident report dated January 28, 2008 indicated that Resident #1 received a burn to her right foot after the foot slid under a radiator in the bathroom, while transfering to the commode. The resident relied on staff assistance with transfers to/from her wheelchair to the commode. In addition, review of staff meeting agendas revealed references made regarding Resident #4 receiving assistance and/or support with going on "dates."	I 229	The Physical Therapy training was completed The recreational inservice was completed on The Sexuality in service was completed on Refer to attachment # 6 a, b, c, In the future, the facility will ensure that all of training are completed as scheduled.	4-04-08 4-29-08 4-29-08
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute Is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that medications were administered as prescribed, for three of the four residents of the facility. (Residents #1, #2 and #4) The findings include: The morning medication administration pass was observed on April 2, 2008, beginning at 7:13 AM. The following errors were observed: 1. At 7:16 AM, the trained medication employee (TME) squeezed 1 spray of Flonase nasal spray into Resident #1's left and right nostrils. The resident, however, did not take in a breath at the appropriate moments when the nurse squeezed	I 422	All of the facility TMEs were trained on the medication administration refer to attachment #5 In the future, the facility will ensure that all of medications are administrated as prescribed by the physician.	4-29-08

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I 422	Continued From page 2 the nasal spray bottle. The TME did not offer the resident any instructions during this process. The TME was not observed using effective means to ensure that Resident #1 received her prescribed nasal spray in accordance with the physician's orders. 2. At 7:55 AM, the TME poured Resident #2's liquid Dilantin into a medicine cup and placed it on top of a file cabinet. The resident's orders were to receive 4 ml of liquid, or 100 mg Dilantin. As the TME reached for the medicine cup to take to the resident, who was seated at the breakfast table in her wheelchair, she indicated that she was about to administer the medication. Observation of the medicine cup revealed that there was only 2.5 ml of liquid poured. After this was brought to the TME's attention, she added another 1.5 ml to equal 4 ml. 3. At 7:48 AM, the TME squeezed 1 spray of Advair discus inhaler into Resident #4's mouth. The resident, however, did not take in a breath at the appropriate moment when the nurse squeezed the Advair discus. The TME did not offer the resident any instructions during this process. The TME was not observed using effective means to ensure that Resident #4 received her prescribed medication in accordance with the physician's orders. 4. At 7:55 AM, Resident #4 was observed making a deep, gurgling cough. She gave four coughs repeatedly at that time. The resident coughed again at 8:13 AM and several more times at 9:03 AM. Observations later that day included several deep, bubbly coughs in succession at 4:19 PM. At that time, her face turned red as she coughed. Verification of the medication pass on the following day, April 3,	I 422	All the facility TMEs were trained on the medication administration refer to attachment #5 In the future, the facility will ensure that all of medications are administrated as prescribed by the physician. All the facility TMEs were trained on the medication administration refer to attachment #5 In the future, the facility will ensure that all of medications are administrated as prescribed by the physician. All of the facility TMEs were trained on the medication administration refer to attachment #5 In the future, the facility will ensure that all of medications are administrated as prescribed by the physician.	4-29-08 4-29-08 4-29-08

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I 422	Continued From page 3 2008, revealed PRN ("as needed") physician's orders for "Bromatane DX cough syrup, 5 ml by mouth, 4 times daily as needed for congestion." Resident #4 had not been observed receiving cough syrup the previous day when she coughed. At 1:28 AM, interview with the RN revealed that the cough syrup should be administered if she had "a persistent cough, that doesn't stop." When asked if she should have taken the cough syrup when she had a deep, bubbly cough, the RN replied "yes," that would indicate congestion. At approximately 4:40 PM, interview with the Director of Nursing yielded similar discussion. Coughing would help the resident clear her lungs of congestion. She affirmed that Bromatane was an expectorant, not a suppressant; therefore it should have been administered in accordance with physician's orders.	I 422	All of the facility TMEs were trained on the medication administration refer to attachment #5 In the future, the facility will ensure that all of medications are administrated as prescribed by the physician.	4-29-08
I 427	3521.5(d) HABILITATION AND TRAINING Each GHMRP shall make modifications to the resident ' s program at least every six (6) months or when the client: (d) Is being considered for training toward a new objective or objectives; or... This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure that baseline behavioral data was collected for Resident #3, with intervention program(s) established, as deemed necessary and appropriate by her interdisciplinary team review and recommendations. The findings include: On April 2, 2008, at 7:32 AM, Resident #3 walked	I 427		

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I 427	Continued From page 4 out of her bedroom and came through the living room on her way to the dining room. She stopped next to a floor lamp in the living room, leaned forward and placed her nose (briefly) against the lamp shade, before continuing to the dining room. A moment later, she bent over and touched her nose to a bouquet of artificial flowers that were in the center of the table. At approximately 8:15 AM, she repeated this behavior, when she placed her nose briefly against the back of her dining room chair. During the entrance conference, at 9:10 AM that morning, the Residential Team Leader (RTL, aka House Manager) indicated that the resident had exhibited the nose-ing behavior since she was admitted to the facility in June 2007. The resident would rub her nose on facility walls as well, leaving mucous on the walls. This reportedly had been especially heavy in December 2007, when she was treated for a sinus infection. The behavior, however, had not yet been assessed by their psychologist. The RTL further stated that the psychologist was expected to come to the facility to assess the resident's nose-ing behavior and to provide appropriate recommendations. Although Resident #3 was not in the sample, a focused review of her admission documentation was conducted because she had been admitted to the facility within the past twelve (12) months. On April 4, 2008, beginning at 2:40 PM, review of Resident #3's record confirmed that she was admitted on June 29, 2007. A psychologist assessed her shortly thereafter. In the Psychological Evaluation, dated July 30, 2007, the psychologist recommended collecting baseline data, to be reviewed at the end of August 2007. Further review of the record	I 427	Staff did collect data to baseline individual #3 behaviors of concerns for 30 days as recommended by the Psychologist; however, based on the data collection, there was no sufficient data that indicated the intensity of this behavior, and also individual #3 was diagnosed with Sinus. Since the behavior has reoccured, the Psychologist is updating individual #3 baseline for her behaviors of concerns. In the future, the facility will ensure that all behaviors are address as they occur.	5-19-08

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I 427	Continued From page 5 showed no evidence that staff had collected baseline data since then or that the psychologist had reviewed Resident #3's behavioral needs in the eight (8) months that ensued.	I 427		
I 484	3522.11 MEDICATIONS Each GHMRP shall promptly destroy prescribed medication that is discontinued by the physician or has reached the expiration date, or has a worn, illegible, or missing label. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure that all prescribed medications, including topical lotions, were destroyed when they reached their expiration date. The findings include: On April 4, 2008, at approximately 4:48 PM, observation of Resident #4's toiletry kit revealed the following: 1. The label on a tube of Triple Antibiotic ointment reflected a September 29, 2007 expiration date; 2. The label on a tube of Lotrisone Cream reflected a June 8, 2007 expiration date; and 3. The label of a container of Urea 40% cream indicated that it had expired on January 28, 2008. The Residential Team Leader, who was present at the time, confirmed that the lotions' expiration dates had passed.	I 484	All of the expired topicals were removed from the toileting kit, and destroyed. In the future, the facility will ensure that all of medications including topicals are removed and destroyed when they reach their expiration date. Refer to I 484 (1) P. 6 Refer to I 484 (1) P. 6 Refer to I 484 (1) P. 6	4-04-08 4-08-08 4-08-08 4-08-08

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R 000	INITIAL COMMENTS	R 000		
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on the review of records, the GHMRP failed to ensure criminal background checks disclosed the criminal history of any prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker had worked or resided within the seven (7) years prior to the check. The finding includes: On April 3, 2008, beginning at 4:09 PM, review of personnel records revealed that the RTL (aka House Manager) had only obtained a partial background check (for Maryland and DC) at the time she was hired. Review of her resume revealed that at the time that she applied with this agency, she was employed by a nursing home in Fairfax, Virginia. She had been employed there beginning August 25, 2004. There was no evidence of a background check that included the jurisdiction (Virginia). This is a repeat deficiency. This was cited last year; however, there was no evidence that the	R 125	All of the personnel files are currently updated	4-07-08

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R 125	Continued From page 1 facility had obtained an updated background check, to include Virginia. Previously, the May 11, 2007 deficiency report included the following: Review of the personnel records on May 10, 2007 revealed that the GHMRP failed to provide evidence that ensured criminal background checks were on file and disclosed a seven year history of all the jurisdictions where the employee resided and worked for the House Manager and one direct care staff.	R 125	All of the personnel files are currently updated	4-07-08